

2013-08-12 15:00

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
FORM APPROVED  
CASE 101-1094-2581

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DEFICIENCY IDENTIFICATION NUMBER		DEFICIENCY DESCRIPTION		DEFICIENCY STATUS	
		448174		A. N/A		08/12/2013	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
BROOKHAVEN MANOR				3045 STONEDOCK PLACE POSDORF, TN 37088			
DATE OF DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCY (BASIC DEFICIENCY MUST BE PRECEDED BY ALL REGULATORY OR LICENSING REQUIREMENTS)	NO. DEFICIENCY	DEFICIENCY PLAN OF CORRECTION (BASIC DEFICIENCY MUST BE PRECEDED BY ALL REGULATORY OR LICENSING REQUIREMENTS)		DATE CORRECTED		
P 000	INITIAL COMMENTS	F 000					
P 241	<p>AN INITIAL REASSESSMENT survey and complaint investigation #21065, #31023, #32081, and #32140, were completed on August 5-7, 2013, at Brookhaven Manor. No deficiencies were cited related to complaint investigation #31023 and #32140. Deficiencies were cited related to complaint investigation #21065 and #32081 under 42 CFR Part 482.13, Requirements for Long Term Care Facilities.</p> <p><b>482.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>The REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, observations, and interviews, the facility failed to ensure dignity for one resident (#442) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #442 was admitted to the facility on June 18, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Congestive Heart Failure, and Chronic Kidney Disease.</p> <p>Medical record review of the Quarterly Minimum Data Set dated July 17, 2013, revealed the resident was cognitively intact, was totally dependent for dressing, personal hygiene,</p>	F 241	<p>Resident #442's call light was answered and personal care was provided.</p> <p>Interviews with residents were then conducted by members of the interdisciplinary team on 08/20/13 and 08/21/13 to determine if any other residents have had their call lights answered or not when needed care.</p> <p>All staff have been re-educated by NHA, Park Manager on or before 08/20/13, on resident rights and what it means to maintain the dignity of the residents. Call light audits will be performed by DCA or designated three (3) people per week for weeks (1) weeks to ensure call lights are being answered properly. Department managers have been assigned daily rounds to ensure residents' needs are being met.</p> <p>Results of the call light audits and interviews will be brought to CA presentation for review. The DCA, Administrator, or designee will ensure compliance.</p>		08/20/13		

OPERATORY DIRECTOR'S OR SUPERVISOR'S SIGNATURE

TITLE

DATE

The following statement is being made with an understanding that the information may be obtained from reviewing personnel in the community and/or subsequent providers involved in the patient's care. The information is being provided for nursing home use only and is not to be used for any other purpose. For nursing home use only, the information is being provided for nursing home use only and is not to be used for any other purpose. For nursing home use only, the information is being provided for nursing home use only and is not to be used for any other purpose.

DATE (MM/DD/YYYY) PROVIDED TO THE COMMUNITY

DATE (MM/DD/YYYY)

DATE (MM/DD/YYYY)

IF CONTINUATION SHEET PAGE 1 OF 33

2013-08-12 15:00

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2469280 P 5/34

PRINTED: 08/12/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  446174	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 1</p> <p>bathing, and was always incontinent of bowel and bladder.</p> <p>Observation on August 5, 2013, at 4:00 p.m., revealed the resident turned on the call light. Continued observation revealed the call light was turned off at 4:03 p.m.</p> <p>Interview on August 5, 2013, at 4:20 p.m., with the resident, in the resident's room revealed the resident had turned on the call light and requested to have a wet brief changed. Continued interview revealed a staff member turned the call light off and said they would return. Continued interview revealed the resident stated "don't like I've...on myself, sometimes wait 3 or 4 hours to be changed."</p> <p>Observation on August 5, 2013, at 4:36 p.m., revealed the resident turned on the call light. Continued observation revealed Certified Nursing Assistant (CNA) #2 entered the resident's room at 4:45 p.m. Continued observation with CNA #2 revealed the resident's brief was saturated with urine.</p> <p>Interview with the Director of Nursing on August 6, 2013, at 3:55 p.m., in the conference room confirmed forty-five minutes was too long to wait for incontinence care to be provided.</p>	F 241			
F 242 SS=D	<p>C/O #32091</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;</p>	F 242			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 2</p> <p>Interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the shower schedule, observation, and interview, the facility failed to provide showers for one resident (#31) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #31 was admitted to the facility on December 29, 2011, and readmitted to the facility on April 17, 2013, with diagnoses including Cerebrovascular Disease, Hemiplegia, Atrial Fibrillation, and Hypertension.</p> <p>Medical record review of the Quarterly Minimum Data Set dated May 19, 2013, revealed the resident had moderately impaired cognitive skills for daily decision making and was totally dependent for personal hygiene and bathing.</p> <p>Medical record review of the Nursing Weekly Summary dated July 31, 2013, revealed "...Alert (and) verbal able to make needs known..."</p> <p>Medical record review revealed no documentation when the resident received a shower.</p> <p>Review of the shower schedule revealed the resident was scheduled for showers on Monday, Wednesday, and Friday, on the 2:00 p.m. to 10:00 p.m. shift.</p>	F 242	<p>Resident # 31 was given a shower the same day that Brookhaven was made aware of the resident's request.</p> <p>Residents who are able will be interviewed to determine if they have been affected. Interviews completed by members of Interdisciplinary Team on 08/20/13 and 08/21/13. Audits of showers will be performed by DON or designee three (3) times per week for twelve (12) weeks. CNAs and Licensed nurses have been inserviced by RN, Risk Manager on or before 08/23/13 regarding resident's right to make choices about frequency of showers. Upon admit resident's choices regarding bathing will be noted and included on the CNA Kardex (care plans). These Kardexes will be updated routinely. Results of audits and interviews will be brought to the QA committee for review. DON or designee to ensure compliance.</p>	09/20/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	Continued From page 3 Observation and interview with the resident, on August 5, 2013, at 4:30 p.m., in the resident's room revealed the resident stated does not get a shower, "say they don't have enough help."  Observation and interview with the resident on August 7, 2013, at 8:00 a.m., in the resident's room revealed the resident stated, "I don't get a shower once a week, don't like to stink, I get a bed bath at 8:00 or 9:00 at night, they tell me they don't have enough help." Continued interview with the resident revealed the resident was able to state the correct month, president, and year of birth.  Interview on August 7, 2013, at 3:00 p.m., with the Director of Nursing, in the conference room, confirmed no documentation the resident received a shower three times a week.	F 242			
F 246 SS=D	C/O #32091 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to provide care in a reasonable time to	F 246			

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2469280 P 8/34

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	<p>Continued From page 4</p> <p>meet incontinent needs for one resident (#43) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #43 was admitted to the facility on June 19, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes, Congestive Heart Failure, and Chronic Kidney Disease.</p> <p>Medical record review of the Quarterly Minimum Data Set dated July 17, 2013, revealed the resident was cognitively intact, and was totally dependent for dressing, personal hygiene, bathing, and was always incontinent of bowel and bladder.</p> <p>Review of the facility policy, Call Light, Use of, revealed "...Answer all call lights promptly whether or not you are assigned to the resident..."</p> <p>Observation on August 5, 2013, at 4:00 p.m., revealed the resident turned on the call light. Continued observation revealed the call light was turned off at 4:03 p.m.</p> <p>Interview with the resident on August 5, 2013, at 4:20 p.m., in the resident's room revealed the resident had turned on the call light and requested to have a wet brief changed. Continued interview revealed a staff member turned the call light off and said they would return. Continued interview revealed the resident stated "don't like I've...on myself, sometimes wait 3 or 4 hours to be changed."</p> <p>Observation on August 5, 2013, at 4:38 p.m., revealed the resident turned on the call light,</p>	F 246	<p>Resident #43's call light answered and per-care provided. Interviewable residents have been interviewed by members of the Interdisciplinary Team on 08/20/13 and 08/21/13 to determine if any other residents have been affected and have not received reasonable accommodation for their individual needs and preferences. CNA's and Licensed nurses have been inserviced by RN, Risk Manager on or before 08/23/13 on incontinent care and the resident's right to have their needs met. Incontinent care audits will be performed by DON or designee three (3) times a week for twelve (12) weeks. Department Managers have been assigned daily rounds to ensure residents' needs are being met.</p> <p>Results of audits and interviews will be brought to the QA committee for review. The DON or designee will ensure compliance.</p>	09/20/13	

CRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 5 of 23

2013-08-12 15:01

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2469280 P 9/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	Continued From page 5 continued observation revealed CNA #2 entered the resident's room at 4:45 p.m. Continued observation with CNA #2 revealed the resident's brief was saturated with urine.  Interview with the Director of Nursing on August 6, 2013, at 3:56 p.m., in the conference room confirmed forty-five minutes was too long to wait for incontinence care to be provided.	F 248			
F 253 SS=E	C/O #32091 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to maintain a clean environment in two of four shower rooms observed.  The findings included:  Review of facility policy, Shower Stalls, (no date) revealed "...shower stalls should be cleaned frequently to remove these fungi...wash walls and floor...inspect for appearance and odor..."  Observation on August 5, 2013, at 9:20 a.m., of the 200 hall shower room revealed a black substance on the floor and the walls in the shower area. Continued observation revealed the metal door frame around the entry door to the	F 253	Shower rooms to be cleaned daily by Environmental Services. The walls, stalls, and floor to be top scrubbed once weekly by Environmental Services. Shower rooms to be monitored by Environmental Services Director or designee three (3) times per week for twelve (12) weeks. Environmental Services Director or designee to ensure compliance. All audits will be brought to QA committee for review for next three (3) months.	09/20/13	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N221F11

Facility ID: TN8203

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2013-08-12 15:02

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2469280 P 10/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	Continued From page 8 shower area was rusted and had jagged edges.  Further observation at 9:45 a.m. of the 400 hall shower room revealed a black substance on the floor and the walls in the shower area. Continued observation revealed the metal door frame around the entry door to the shower area was rusted and had jagged edges.  Observation with the Director of Environmental Services on August 7, 2013, at 9:10 a.m., in the 400 hall shower room revealed a black substance on the floor and walls in the shower area. Interview during the observation revealed "...showers are cleaned daily and a deep cleaning is done on Sunday..." Further interview confirmed "...it is mildew and has been there at least 2 days...don't think they have been cleaned..."  Observation with the Director of Environmental Services on August 7, 2013, at 9:20 a.m., in the 200 hall shower room revealed a black substance on the floor and walls in the shower area. Interview during the observation confirmed "...again that is mildew..."  Observation and interview with the Administrator on August 7, 2013, at 9:30 a.m., of the 200 and 400 hall shower room door frames confirmed the metal door frames were "broken and decayed" leaving rough edges on the bottom of the frames.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279			

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2469280 P 11/34

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2038 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 7</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to develop and revise a Comprehensive Plan of Care for one resident (#145) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #145 was admitted to the facility on February 12, 2011, with diagnosis including Hypertension, Alzheimer's, Convulsions, Cerebral Vascular Accident, Dysphagia, and Osteoarthritis.</p> <p>Review of the Minimum Data Set (MDS) dated July 15, 2013, revealed "...Section H - Bladder and Bowel...: Urinary Continence 3, Always Incontinent (no episodes of continent voiding)..."</p> <p>Medical record review of the Comprehensive</p>	F 279	<p>Care plan for resident #145 has been corrected to include bowel and bladder incontinence .</p> <p>All resident incontinent of bowel and bladder have potential to be affected.</p> <p>All MDSC's Inserviced by MDS Coordinator on 08/19/13 on need to care plan residents who are incontinent of bowel and bladder and care plan needs to reflect needs of resident.</p> <p>MDS Coordinator or designee to audit all comprehensive assessment for twelve (12) weeks of residents that are incontinent to assure that care plans reflect needs of resident, correct as needed.</p> <p>Results of audits will be brought to the QA committee for review.</p>	09/20/13	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

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No. 3332 P. 12

Aug. 23. 2013 5:12PM BROOKHAVEN MANOR



2013-08-12 15:02

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2469280 P 12/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37650		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 8 Care Plan dated July 17, 2013, revealed "...Problem onset July 17, 2013...Potential for urinary tract infection...continent of urine...Problem onset July 17, 2013, Potential for skin breakdown...Continent of B&B (bowel and bladder)..."	F 279			
F 312 SS=D	Interview with the MDS Coordinator on August 7, 2013, at 7:30 a.m., in the MDS Coordinator's office confirmed the Comprehensive Care Plan did not reflect the needs of the resident and had not been revised. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide incontinence care timely for one resident (#160) of forty-two residents reviewed.  The findings included:  Resident #160 was admitted to the facility on January 24, 2011, and readmitted to the facility on February 16, 2011, with diagnoses including Hypertension, Congestive Heart Failure, and Dysphagia.  Medical record review of the Quarterly Minimum	F 312	Resident #160 was provided with re-positioning and incontinent care. A body/skin audit has been performed by Treatment nurse on 08/19/13 on all residents that require total assistance with activities of daily living and personal hygiene/care to ensure no other residents have been affected. CNAs and Licensed Nurses have been inserviced by RN, Risk Manager on or before 08/23/13 on importance of re-positioning and proper incontinent care. Re-positioning audits will be performed by DON or designee each day for one (1) week, three (3) times per week for three (3) weeks and weekly thereafter. Results of audits will be brought to the QA committee for review. DON or designee to ensure compliance	09/20/13	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 9 of 23

No. 3332 P. 13

Aug. 23, 2013 5:12PM BROOKHAVEN MANOR

2013-08-12 15:03

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2469280 P 13/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 9 Data Set dated July 22, 2013, revealed the resident had severe impairment in cognitive skills, was totally dependent for personal hygiene, bathing, and was always incontinent of bowel and bladder.  Observation on August 6, 2013, at 1:10 p.m., 1:45 p.m., and 4:30 p.m., revealed the resident seated in a gerichair in front of the nursing station.  Interview with Certified Nursing Assistant (CNA) #1 on August 6, 2013, at 4:30 p.m., at the nursing station confirmed resident #160 had not been repositioned or incontinence care provided since arriving on duty at 2:00 p.m. Continued interview with CNA #1 revealed CNA #1 stated "I've been busy, getting to (resident) now."  Observation with CNA #1, on August 6, 2013, at 4:35 p.m., revealed the resident had been incontinent of urine in the brief.  Interview with Licensed Practical Nurse (LPN) #4 on August 6, 2013, at 4:50 p.m., at the nursing station confirmed residents were to be repositioned and checked for incontinence every two hours.	F 312			
F 314 SS=D	C/O #32091 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8208

If continuation sheet Page 10 of 23

No. 3332 P. 14

BROOKHAVEN MANOR

Aug. 23, 2013 5:13PM

2013-08-12 15:03

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2469280 P 14/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 10</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to timely obtain a dietary consultation, and to timely initiate and administer a vitamin as ordered for one resident (#168) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #168 was admitted to the facility on July 18, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Fractured Neck of Femur, Bipolar Disorder, Osteoporosis, Hypertension, Convulsions, and Chronic Pain.</p> <p>Medical record review of an Admission Nursing Note dated July 18, 2013, revealed "...open area to sacrum/coccyx..."</p> <p>Medical record review of a Nursing Weekly Summary dated July 25, 2013, revealed "Res (resident) with Stg (Stage) 2 to coccyx..."</p> <p>Medical record review of a Physician's Order dated July 26, 2013, revealed the resident was to receive Decubivite (vitamin) twice a day for thirty days.</p> <p>Medical record review of the August 1-6, 2013, Medication Administration Record revealed no documentation the resident had received the Decubivite as ordered.</p>	F 314	<p>Resident #168's MAR was updated with decubivite; RD assessed resident and new orders noted. Residents with pressure ulcers were checked by Dietary Manager on 08/19/13 for RD notification and if not, it was done.</p> <p>CDM or designee will notify the Dietician within two (2) business days of any new pressure wounds or in-house. All new in-house or admit with will be discussed in morning meeting with IDT.</p> <p>CDM or designee will check weekly during wound meeting for notification. CDM will ensure compliance. Audits will be discussed in QA meeting for any trends, and follow up as needed.</p>	09/20/13	

2013-08-12 15:03

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2469280 P 15/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37680		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>Medical record review revealed no documentation the Registered Dietician had evaluated the resident's nutritional needs until August 6, 2013.</p> <p>Medical record review of a Registered Dietician's note dated August 8, 2013, revealed "...Decubivite ordered 7/28/13...Smoking negatively influences wound healing. Recommend Juven (protein supplement) BID (twice a day) until PU (pressure ulcer) healed.</p> <p>Review of facility. Wound Care Protocols, revealed "...Stage II Characteristics: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Treatment:...Initiate multivitamin until area is healed...Obtain dietary consult..."</p> <p>Observation with the Assistant Director of Nursing (ADON), on August 7, 2013, at 11:06 a.m., revealed Licensed Practical Nurse (LPN) #1 providing wound care to the resident. Continued observation revealed the dressing was removed from the coccyx revealing a wound described by the ADON as a Stage II pressure ulcer measuring 1.0 cm (centimeter) by 0.7cm.</p> <p>Interview with the Director of Nursing (DON) on August 7, 2013, at 7:26 a.m., in the conference room, confirmed there was a delay in initiating the Decubivite and the Physician's Order for Decubivite was not followed on August 1-6, 2013. Continued interview with the DON revealed the Registered Dietician was not notified of the resident's pressure until August 6, 2013, and confirmed there was a delay in obtaining a</p>	F 314			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 12 of 23

No. 3332 P. 16/35

BROOKHAVEN MANOR

Aug. 23. 2013 5:19PM

2013-08-12 15:03

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2469280 P 16/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314 F 323 SS=D	<p>Continued From page 12</p> <p>consultation by the Registered Dietician, 483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, review of facility policy, observation, and interview, the facility failed to ensure interventions were in place related to falls for two resident's (#1, #63) for forty-two residents reviewed.</p> <p>The findings included;</p> <p>Resident #1 was admitted to the facility on September 5, 2007, with diagnoses including Hypertension, Congestive Heart Failure, Atrial Fibrillation, Cerebral Vascular Accident with left sided paralysis, Diabetes and Anemia.</p> <p>Medical record review of a significant change Minimum Data Set (MDS), dated May 13, 2013, revealed the resident scored a fourteen on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact and required extensive assistance with activities of daily living.</p> <p>Medical record review of a fall assessment dated</p>	F 314 F 323	<p>The interventions for residents' #1 and #63 have been put into place and are functioning as designed. An audit of all safety interventions in facility has been completed by Risk Manager on 08/23/13 to ensure that no other residents have been affected. Audits of all safety devices will be continued by DON or designee for three (3) times for four (4) weeks then two (2) times a week for four (4) weeks and then one (1) time per week from that date forward.</p> <p>New safety interventions will be reviewed in Morning meeting and then relayed to Unit Managers or designee to ensure that the interventions are in place. All CNAs and Licensed nurses have been inserviced by RN, Risk Manager on or before 08/23/13 on facility policy regarding resident care plans and Kardex.</p> <p>Results of audits will be brought to the QA committee for review. DON or designee to ensure compliance.</p>	09/20/13	

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Rev#1 ID: N22H11

Facility ID: TN4203

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No. 3332 P. 17/35

BROOKHAVEN MANOR

Aug. 23. 2013 5:19PM

2013-08-12 15:04

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2469280 P 17/34

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FORM APPROVED  
OMB NO. 0938-0381DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 13</p> <p>July 12, 2013, revealed the resident scored a fourteen on the assessment indicating the resident was at risk for a fall.</p> <p>Medical record review of the Care Plan dated July 31, 2013, revealed "...potential for falls due to non-ambulatory status...supervision while toileting..."</p> <p>Medical record review of a Nurse's Note dated July 12, 2013, at 1945 (7:45 p.m.), revealed the resident was found in the floor in the bathroom in the resident's room. Continued review revealed "...observed resident laying on the left side with...head and neck area at BR (bathroom) door...stated hit...head when...fell off the toilet..." Continued review revealed "...no redness noted...skin w/d (warm and dry to touch)...was given scheduled MS Contin (medication for pain)..."</p> <p>Review of a witness statement report dated July 12, 2013, written by a Certified Nurse Assistant (CNA) #4 revealed "...took resident to toilet after supper and...told me to give...emergency light and give...privacy...a short time later...was on my way to check on resident since light had not come on ...heard resident calling for help...on reaching the room resident was in the floor in front of the toilet..."</p> <p>Review of a facility investigation dated July 12, 2013, revealed "...resident observed laying on left side in floor of restroom...resident had been assisted to toilet by staff...resident reports dropping the call light cord and being unable to retrieve it..."</p> <p>Review of facility policy, Falls and Falls Risk,</p>	F 323			

2013-08-12 15:04

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2469280 P 18/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  446174		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 323	<p>Continued From page 14</p> <p>Managing, with a revision date of December 2007 revealed "...staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling..."</p> <p>Observation on August 6, 2013, at 2:30 p.m., in the resident's bathroom, revealed a call light cord with a red extension cord applied to the call light cord.</p> <p>Observation on August 6, 2013, at 4:30 p.m., in the hallway outside of the resident's room revealed the resident sitting in the wheelchair and a splint to the left upper extremity due to paralysis to the left side.</p> <p>Observation on August 7, 2013, at 7:50 a.m., in the resident's room revealed the resident in the room and the Hospice Nursing Assistant assisting the resident with bathing.</p> <p>Telephone interview with CNA #4 on August 15, 2013, at 10:35 a.m., revealed "...wanted to go to the bathroom during supper tray pass...took the resident to the bathroom...states the resident told me you can come back, it's going to be awhile...gave...the call light...it was a short cord...I left the room...came back in about ten minutes later and heard resident yelling...had fallen in the floor...dropped the call light and could not reach it..."</p> <p>Interview with the Director of Nursing (DON) on August 7, 2013, at 9:56 a.m., in the DON office revealed "...would not have left the resident in the bathroom by herself..." Continued interview confirmed the CNA did leave the resident in the bathroom unattended, the call light cord was to</p>	F 323				

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Event ID: N22H11

Facility ID: TN0203

If continuation sheet Page 16 of 23

No. 3332 P. 19/35

BROOKHAVEN MANOR

Aug. 23. 2013 5:19PM

2013-08-12 15:04

DC0547PM13501

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2469280 P 19/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 15</p> <p>short for the resident, the resident was at risk for fall, and the facility had failed to ensure a safe environment for the resident.</p> <p>Resident # 63 was admitted to the facility on March 8, 2013, with diagnoses including Pelvic Fracture, Congestive Heart Failure, Osteoporosis, Dysphagia, Chronic Obstructive Pulmonary Disease, and Esophageal Gastric Reflux.</p> <p>Review of the quarterly Minimum Data Set (MDS), dated June 3, 2013, revealed the resident scored a three on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired and required extensive assistance with activities of daily living.</p> <p>Medical record review of a Nurse's Note dated August 2, 2013, at 11:00 p.m., revealed "...summons to room, resident sitting in floor beside the bed...alarms sounding...w/c (wheel chair) to the side behind the resident...one wheel locked..."</p> <p>Medical record review of a Physician's Order dated August 5, 2013, 10:20 a.m., revealed "...anti-rollback bar to w/c..."</p> <p>Medical record review of the Care Plan dated August 5, 2013, revealed "...anti-rollback bar to w/c..."</p> <p>Observation on August 8, 2013, at 5:22 p.m., in the hallway outside of the resident's room revealed the resident in the wheelchair with no anti-rollback bar on the wheelchair.</p> <p>Interview with the Assistant Director of Nursing (ADON) on August 8, 2013, at 5:25 p.m., in the</p>	F 323			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 18 of 28

55/07 P. 3332 No. 3332

BROOKHAVEN MANOR

Aug. 23. 2013 5:20PM



2013-08-12 15:05

DC0547PM13501

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2469280 P 20/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 16	F 323			
F 364 SS=D	<p>resident's room confirmed the anti-rollback bar was not in place on the resident's wheelchair. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was maintained at appropriate temperatures on one of four hallways.</p> <p>The findings included:</p> <p>Observation on August 7, 2013, revealed the food cart arrived on the 300 hallway at 8:40 a.m. Continued observation revealed the last food tray was delivered to the residents on the hallway at 9:15 a.m.</p> <p>Interview with resident #168 on August 6, 2013, at 8:06 a.m., in the resident's room revealed the eggs were always not warm enough at breakfast.</p> <p>Observation and interview with the Dietary Manager on August 7, 2013, at 9:15 a.m., on the 300 hallway revealed a test tray was removed from the cart and confirmed the eggs and food items were not warm enough.</p>	F 384	<p>The tray tested on 300 wing was a test tray. Residents interviewed by members of the Interdisciplinary Team on or before 08/30/13 on food quality and temp. Dietary Manager to perform test (tray audits three (3) times a week for twelve (12) weeks. Dietary Manager to ensure compliance. CDM to inservice all Dietary staff on or before 08/30/13 on proper plate temperatures. All audits will be brought to QA committee for three (3) months for review.</p>	09/20/13	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	F 411			

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Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 17 of 23

No. 3332 P. 21/35

BROOKHAVEN MANOR

Aug. 23, 2013 5:20PM

2013-08-12 15:05

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2469280 P 21/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37660		
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F 411	<p>Continued From page 17</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a dental consult for one resident (#218) of forty-two residents reviewed.</p> <p>The findings included:</p> <p>Resident #218 was admitted to the facility on April 30, 2013, with diagnoses including Pneumonia, Chronic Airway Obstruction, Multiple Organ Failure with Sepsis, Marfan Syndrome, Spinal Stenosis, Thoracic Aortic Aneurysm, Osteoarthritis, Ventral Hernia, Anxiety, Alcohol Abuse, and Degenerative Disk Disease.</p> <p>Medical record review of the admission Minimum Data Set (MDS) dated May 7, 2013, revealed the resident had likely cavity or broken natural teeth.</p> <p>Medical record review of the Nutritional Evaluation dated May 9, 2013, revealed "...Due to teeth loss not able to eat carrot sticks..."</p>	F 411	<p>Resident #218 was discharged home, he will follow up as outpatient.</p> <p>100% audit review completed of resident charts by Social Services Director on 08/22/13. Residents with BIM score of 10 or above were interviewed to determine if they requested a consultation. During initial interview for all new residents, Social Services will educate residents regarding services provided by facility, such as dental services. Social Services will ask resident if they are in need of any services. If so, resident's name will be placed on dental list for upcoming visit. If resident is short-term and expects to discharge before dental visit, Social Services will offer to schedule a dental appointment for resident.</p> <p>During quarterly, annual, and significant change assessments, Social Services will remind residents about services facility offers, such as dental. The resident will be asked if they are in need of any services, if so their name will be added to the dental list. Social Services Director will ensure compliance. All requests will be brought to QA committee for three (3) months to review.</p>	09/20/13	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 18 of 23

No. 3332 P. 22/35

BROOKHAVEN MANOR

Aug. 23, 2013 5:20PM

2013-08-12 15:05

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2469280 P 22/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

BROOKHAVEN MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

2038 STONEBROOK PLACE  
KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X8) COMPLETION DATE
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F 411 Continued From page 18

Medical record review of the Care Plan reviewed on August 1, 2013, revealed "...Resident has potential for weight change...Dental consult as needed..."

Medical record review revealed no documentation a dental consult had been obtained.

Observation on August 5, 2013, at 11:20 a.m., revealed the resident lying on the bed. Interview with the resident during the observation revealed the resident had chewing and eating problems due to no upper teeth and only seven teeth on the bottom.

Interview with Registered Nurse (RN) #1 on August 6, 2013, at 2:00 p.m., in the MDS office confirmed the resident had not received a dental consult.

F 431  
SS=D 483.60(b), (d), (e) DRUG RECORDS,  
LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

F 411

F 431

Multi-use vial on #2 med cart on 400 hall was removed and discarded.  
Residents with insulin orders were checked by Unit Manager on 08/08/13 for expiration date and proper storage.  
Licensed staff were inserviced by RN, Risk Manager on or before 08/23/13 on facility policy for med storage and labeling.  
DON or designee will check all insulin vials for correct storage, expiration date, and labeling for three (3) weeks for twelve (12) weeks. DON to ensure compliance. Audits will be discussed in QA meeting for any trends, and follow up as needed.

09/20/13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN8203

If continuation sheet Page 18 of 23

No. 3332 P. 23/35

BROOKHAVEN MANOR

Aug. 23, 2013 5:20PM

2013-08-12 15:06

DC0547PM13501

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2469280 P 23/34

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

BROOKHAVEN MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

2026 STONEBROOK PLACE  
KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 19</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to label and store medications correctly on one of seven medication carts.</p> <p>The findings included: Review of facility policy, Medication Storage in the Facility, revealed "...Medications and biological are stored safely, securely, and properly...Procedures...C. All medications are stored in the box, bag or other container with the pharmacy label...M. Outdated, contaminated...are immediately removed from stock...R. Insulin storage after opening: Insulin is to be dated when opened..."</p> <p>Observation with Registered Nurse (RN) #2 on</p>	F 431		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N221111

Facility ID: TN8203

If continuation sheet Page 20 of 23

2013-08-12 15:06

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2469280 P 24/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

445174

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

08/07/2013

NAME OF PROVIDER OR SUPPLIER

BROOKHAVEN MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

2038 STONEBROOK PLACE  
KINGSPORT, TN 37660(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETION  
DATE

F 431

Continued From page 20

August 6, 2013 at 2:10 p.m., of in medication cart #2 on the 400 hall revealed one multi dose vial of Humalog 100 u/ml (units per milliliters) in a plastic bag with an open date written as July 8, 2013, and an expiration date of August 4, 2013. Further observation revealed one opened multi dose vial of Lantus 100 u/ml without a resident's name, the date opened, or the date of expiration. The vial was not in a plastic bag.

F 514  
SS=D

Interview with RN #2 on August 6, 2013, during the observation confirmed the medications were not stored correctly.

483.75(j)(1) RES  
RECORDS-COMplete/ACCURATE/ACCESSIB  
LE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to accurately document the discharge date and failed to maintain a complete medication administration record for one resident (#228) of forty-two residents reviewed.

F 431

F 514

Resident #228 Face sheet has been corrected to accurately reflect the resident's discharge dates. Medical Records Director completed an audit of 100% of face sheets for discharged residents going back three (3) months to ensure no other residents have been affected on 08/22/13.

Medication administration sheets have also been audited by Medical Records Director to ensure proper documentation of insulin administration. Audits will be performed on resident face sheets by DON or designee three (3) times a week for twelve (12) weeks to ensure information on face sheets is accurate.

Licensed staff has been inserviced by Risk Manager on 08/23/13 on facility policy on medication administration and documentation.

Audits of medication administration record will be performed three (3) times per week for twelve (12) weeks.

Results of audits will be brought to the QA committee for review. DON, Administrator, or designee to ensure compliance.

08/20/13

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22H11

Facility ID: TN82n3

If continuation sheet Page 21 of 23

No. 3332 P. 25/35

BROOKHAVEN MANOR

Aug. 23, 2013 5:21PM

2013-08-12 15:06

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2469280 P 25/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37650		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 21</p> <p>The findings included:</p> <p>Resident #228 was admitted to the facility on December 19, 2012, with diagnoses including Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Anemia, and Congestive Heart Failure.</p> <p>Medical record review of the Face Sheet for resident #228 revealed the resident was discharged from the facility on December 28, 2012. Continued review of a Nurse's Note dated December 29, 2012, revealed the resident was to be sent to the local hospital for evaluation and treatment.</p> <p>Interview with the Director of Nursing on August 6, 2013, at 3:00 p.m., in the admission's office confirmed the date on the Face Sheet was incorrect and the resident was discharged from the facility on December 29, 2012.</p> <p>Medical record review of resident #228's July 2012 Physician's Orders revealed Lantus insulin (long lasting insulin) to be administered every night.</p> <p>Medical record review of the Medication Administration Record (MAR) for July 2012 revealed on July 7, 2012, the lantus insulin was not documented as being administered.</p> <p>Interview by telephone with Licensed Practical Nurse (LPN) #1 (nurse on duty on July 7, 2012) on August 7, 2013, at 10:00 a.m., revealed LPN #1 had failed to document on the MAR the insulin being administered. Continued interview with LPN #1 confirmed the insulin was given on July 7,</p>	F 514			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N22K11

Facility ID: TN8203

If continuation sheet Page 22 of 23

No. 3332 P. 26/35

BROOKHAVEN MANOR

Aug. 23. 2013 5:21PM

2013-08-12 15:07

DC0547PM13501

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2469280 P 26/34

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37680		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 22 2012.  Interview with the Director of Nursing (DON) on August 7, 2013, at 12:50 p.m., in the DON's office confirmed the documentation on the MAR for July 2012 was not complete.  C/O # 31665	F 514			